

CHAPTER IV

COVERED SERVICES AND LIMITATIONS

CHAPTER IV TABLE OF CONTENTS

	<u>Page</u>
Freedom Of Choice	1
Medallion 3.0	1
Commonwealth Coordinated Care (CCC) Program	1
Virginia Medicaid Web Portall	1
Rehabilitation Definition	2
Covered Services	1
Providers Of Service	2
Out Of State Rehabilitation Services	3
Intensive Rehabilitation Services	4
Admission Criteria (Including CORF)	4
Guidelines For Initiating And Continuing Therapy	5
Therapeutic Furlough Days	5
Transfer To Acute Care/Readmit To Rehabilitation	5
Discharge/Termination From Services	6
 Provider And Service Requirements For Intensive Rehabilitation Services	 7
Physician	7
Rehabilitative Nursing	8
Physical Therapy	8
Occupational Therapy	10
Speech-Language Pathology	12
Therapist Supervision Of A Therapy Assistant (Applicable To PT, OT, And SLP)	14
Cognitive Rehabilitation Therapy	15
Psychology, Social Work And Therapeutic Recreation Services	16
Prosthetic And Orthotic Services And Other Equipment	17
 Outpatient Rehabilitation Services	 19
Definition Of An Outpatient Rehabilitation Therapy Visit	19
Admission Criteria	19
Providers Of Service	20
Therapist Qualifications & Therapy Modalities-Refer To Intensive Rehab Section	20
Guidelines For Initiating And Continuing Therapy	21
 Coordination Of Rehabilitation Services	 22
Categorization Of Two Subgroups: Acute Vs Non-Acute Conditions	22

Discharge Planning	23
Home Therapies	23
Therapies Provided In Nursing Facilities	24
Rehabilitative Services In Icf/Iid Facilities	24
Rehabilitation Therapy - Specific Modalities	24
Discharge/Termination From Services	25

CHAPTER IV COVERED SERVICES AND LIMITATIONS

FREEDOM OF CHOICE

According to federal requirements 42 Code of Federal Regulations (CFR) 431.51, Medicaid eligible individuals must be offered a choice of service provider(s) and this must be documented in the individual's medical record.

MEDALLION 3.0

In areas where the Medallion 3.0 program is available, many Medicaid individuals receive primary and acute care through mandatory enrollment in managed care organizations (MCOs). Medallion 3.0 MCO individuals may be identified by their MCO Individual Identification Card or by other Medicaid eligibility verification systems. Medicaid individuals enrolled in the traditional Medicaid program will have a regular Medicaid card. MEDALLION 3.0 individuals have a regular Medicaid card and a MCO Individual Identification Card. Except for family planning and emergency services, Medallion 3.0 individuals must utilize providers that participate within the MCO's provider network. Providers must adhere to the MCO's requirements regarding referrals and Service Authorization requirements, otherwise, payment for services may be denied. Providers may not bill the individual for Medicaid covered services, including in those instances where a provider fails to follow the MCO's established guidelines.

Refer to the section entitled "MEDALLION 3.0" in Chapter I of this manual for further details regarding individuals who are enrolled in MEDALLION 3.0.

COMMONWEALTH COORDINATED CARE (CCC) PROGRAM

The Commonwealth Coordinated Care (CCC) program is a new initiative, as of April 2014, to coordinate care for individuals who are currently served by both Medicare and Medicaid and meet certain eligibility requirements. The program is designed to be Virginia's single program to coordinate delivery of primary, preventive, acute, behavioral, and long-term services and supports focused on the individual's needs and preferences. Additional information on the CCC program can be accessed at: http://www.dmas.virginia.gov/Content_pgs/altc-enrl.aspx.

VIRGINIA MEDICAID WEB PORTAL

The Virginia Medicaid Web Portal is the gateway for providers to transact all Medicaid and FAMIS (Family Access to Medical Insurance Security Plan) business via one central location on the Internet. The web portal provides access to Medicaid Memos, Provider Manuals, providers search capabilities, provider enrollment applications, training and education. Providers must register through the Virginia Medicaid Web Portal in order to access and complete secured transactions such as verifying Medicaid eligibility, service limits and service authorization or by submitting a claim. The Virginia Medicaid Web Portal can be accessed at: www.virginiamedicaid.dmas.virginia.gov.

REHABILITATION DEFINITION

Rehabilitation services is medically prescribed treatment designed to improve or restore functions which have been impaired by illness, disability, injury or, where function has been permanently lost or reduced by illness or injury, to improve or restore the individual's ability to perform those tasks required for independent functioning.

COVERED SERVICES

Inpatient and outpatient rehabilitation services are covered services available to the entire Medicaid population. The physician is responsible for certifying that the service is medically necessary and that the treatment prescribed is in accordance with standards of medical practice. Medical necessity is defined as services ordered by a physician; a reasonable and medically necessary part of the individual's treatment plan; consistent with generally accepted professional medical standards (i.e., not experimental or investigational); and is furnished at a safe, effective, and cost-effective level.

PROVIDERS OF SERVICE

The Department of Medical Assistance Services (DMAS) provides coverage for physical rehabilitative services under two programs: outpatient rehabilitation (physical and occupational therapies and speech-language pathology services) and intensive rehabilitation services.

Implemented in 1978, the outpatient rehabilitation services may be provided in hospital outpatient settings of acute care and rehabilitation hospitals, rehabilitation agencies, home health agencies, and nursing facilities.

Implemented in February 1986, the intensive inpatient rehabilitation program provides comprehensive rehabilitation services that include the following: rehabilitation nursing, physical therapy, occupational therapy, cognitive rehabilitation therapy, speech-language pathology services, and, if needed, social work services, psychology, therapeutic recreation, and durable medical equipment. These services may be provided by a freestanding rehabilitation hospital, a Comprehensive Outpatient Rehabilitation Facility (CORF), or by an acute care hospital that has a Medicare-exempt physical rehabilitation unit.

All rehabilitative services must be prescribed by a physician and be a part of a written plan of care/treatment plan that the physician reviews periodically (described later in this chapter).

There are various requirements for physician documentation for intensive rehabilitation, CORF, and outpatient rehabilitation services. Refer to this Chapter and Chapter VI for intensive/CORF and outpatient rehabilitation specific documentation requirements related to the physician, physician assistant, and the nurse practitioner. If therapy services are ordered by a practitioner of the healing arts other than a physician, supervision must be performed by a physician as required by the Virginia Department of Health Professions regulations. (Virginia State Code § 54.1-2400; 42 Code of Federal Regulations (CFR), 440.130, and 485.711).

To be reimbursed for services rendered, each provider must have a valid signed provider agreement and a valid NPI number with the DMAS for the type of services that are being provided. For additional provider information, refer to Chapter II of this manual.

NOTE: For additional services related to children under the age of 21, including but not limited to, EPSDT, Early Intervention Services (EIS), FAMIS and School Services, refer to the Maternal and Child Health Programs section of the DMAS web site at: <http://www.dmas.virginia.gov/Content/pgs/mch-home.aspx>. The DMAS Medicaid web portal contains the program manuals located at: <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>.

OUT OF STATE REHABILITATION SERVICES

[Applicable for both Inpatient & Outpatient Rehabilitation]

DMAS may negotiate individual arrangements with in-state or out-of-state rehabilitation facilities for Virginia Medicaid individuals with special intensive inpatient rehabilitation needs.

Out of state rehabilitation providers are defined as those providers that are either physically outside the borders of the Commonwealth of Virginia or do not provide year end cost settlement reports to DMAS. These providers must be enrolled with Virginia Medicaid (provider class type 091 – Out of State Hospital) in order to submit claims for reimbursement. Service authorization is required.

Out of state or border rehabilitation providers, located close to the proximity of the Virginia state borders (MD, WVA, KY, TN, and NC) and who are enrolled with Virginia Medicaid as a provider class type 085 (Out of State Rehab Hospital) must submit service authorization requests to DMAS or its Service Authorization Contractor as described in Appendix D of this manual.

NOTE: Out of State Providers must refer to the DMAS Medicaid Memo dated February 6, 2013 and also refer to Appendix D titled “Service Authorization Information” of this manual, for more specific information and guidelines.

For those out of state rehabilitation hospital providers who do not meet the above described requirements, a written inquiry may be submitted to DMAS – Division of Long Term Care for additional consideration at: dmas-info@dmas.virginia.gov. Providers must be specific about the services they are requesting and the justification for out of state services. Providers must be enrolled prior to providing services.

NOTE: If Virginia does not offer an inpatient rehabilitation program that provides ventilator weaning, then out of state options may be considered. If a newly acquired ventilator dependent individual within an acute care hospital would benefit from an inpatient rehabilitation program and possible ventilator weaning, the acute care hospital may submit a written inquiry to DMAS - Division of Long Term Care for additional consideration at: dmas-info@dmas.virginia.gov.

Applicable regulations for out-of-state services: 42 CFR §431.52, 12 VAC 30-90-10, 12 VAC 30-10-120, 12 VAC 30-50-225, 12 VAC 30-50-140, 12 VAC 30-60-21, 12 VAC 30-70-420, 12 VAC 30-80-120

INTENSIVE REHABILITATION SERVICES

Intensive rehabilitation program criteria and policy guidelines can be found in the *Virginia Administrative Code*, 12VAC 30-50-225, 12 VAC 30-60-20, and 12 VAC 30-60-120. Effective January 1, 2016, the 12 VAC 30-50-225 and 30-60-120 were revised. Rehabilitation providers have a responsibility to know the regulatory requirements for rehabilitation.

Admission Criteria (Including CORF)

An individual is deemed to require either intensive inpatient rehabilitation services or comprehensive outpatient rehabilitation facility (CORF) services if both of the following criteria are met:

- An intensive rehabilitation program consisting of an interdisciplinary coordinated team approach is required to improve the individual's ability to function as independently as possible; and
- Documentation exists that the rehabilitation program cannot be safely and adequately carried out in a less intensive setting (such as outpatient rehabilitation or home health services).

In addition to the above requirements, individuals must also meet all of the following criteria:

- The individual requires rehabilitative nursing (for patient/family education and teaching in addition to skilled nursing care);
- The individual requires at least two of the four listed therapies:
 - Physical Therapy
 - Occupational Therapy
 - Cognitive Rehabilitation Therapy
 - Speech-Language Pathology Services;
- The individual is able to actively participate in therapy on a daily basis;
- The medical condition is stable and compatible with an active rehabilitation program; and
- The individual meets InterQual® criteria upon admission and for continued stay. The InterQual® criteria may be obtained through McKesson Health Solutions LLC. For the McKesson mailing address, phone and fax numbers and the InterQual® web site address, refer to Appendix D. of this manual, which contains service authorization information.

NOTE: Admissions for evaluation and/or training solely for vocational or

educational purposes or for developmental or behavioral assessments are not covered services.

If the individual had a previous hospital stay and completed a rehabilitation program for essentially the same condition for which this admission is now being considered, reimbursement for the evaluation will not be covered unless a justifiable and documented intervening circumstance necessitates a re-evaluation.

Guidelines for Initiating and Continuing Therapy

[Applicable for both Inpatient & Outpatient Rehabilitation]

- Maintenance Therapy - Interpreted as: 1) the point in therapy where the individual demonstrates no further significant improvement, or 2) the skills of a qualified rehabilitative therapist are not required to carry out an activity or a home program to maintain functioning at the level to which it has been restored. These services are not covered by Medicaid.
- Improvement of Function – Interpreted as rehabilitative therapy designed to improve function and based on an expectation that: 1) the therapy will result in a significant improvement in an individual's level of functioning within a reasonable period of time; 2) there is a valid expectation of improvement at the time the rehabilitative therapy program is implemented; and 3) the services would be recognized even though the expectation may not be realized.

For continued intensive rehabilitation services, the individual must demonstrate an ability to actively participate in goal-related therapeutic interventions developed by the interdisciplinary team and demonstrate progression toward the established goals.

Therapeutic Furlough Days

DMAS will not reimburse an inpatient rehabilitation provider for days when an individual is on an overnight therapeutic furlough. Properly documented rehabilitative reasons for the furlough days should occur as a part of the inpatient rehabilitation program. Such days must not be billed.

Transfer to Acute Care/Readmit to Rehabilitation

When an individual requires transfer to an acute care setting for more than 24 hours, the individual must be discharged from the intensive rehabilitation program. When the individual is medically stable and continued intensive rehabilitation services are appropriate, the individual should be readmitted to the intensive rehabilitation program.

For re-admissions after hospitalizations of more than 24 hours, the rehabilitation treatment team disciplines must re-evaluate the individual's functional status and document the findings in the individual's medical record. Service authorization through the DMAS contractor is required. Each team discipline must review and sign/date the current plan of care/treatment and document whether changes to the current plan are necessary. The physician must document a re-admission note to review the medical necessity for the transfer and the appropriateness for the

individual to continue with the intensive rehabilitation program. Physician admission certification is required to be documented.

Discharge/Termination from Services

[Applicable for both Inpatient & Outpatient Rehabilitation]

Rehabilitation services must be considered for termination, regardless of the service authorized or approved length of stay, when further progress toward the established rehabilitation goal is unlikely or further rehabilitation treatment can be achieved in a less intensive setting, such as in nursing facilities, home and community based settings, home health agencies, and/or outpatient rehabilitation agencies.

Intensive rehabilitation services must be considered for termination when any one of the following conditions is met:

- No further potential for improvement is demonstrated. The specialized knowledge and skills of a licensed/registered rehabilitative therapist are no longer required for safe and effective provision of such rehabilitation services. The individual has reached his/her maximum progress and a safe and effective maintenance program has been developed;
- There is limited motivation on the part of the individual or caregiver;
- The individual has an unstable condition that affects his/her ability to participate in an intensive inpatient/comprehensive rehabilitative plan;
- Progress toward an established goal or goals cannot be achieved within a reasonable period of time;
- The established goals serve no purpose to increase functional or cognitive capabilities; or
- The service can be provided by someone other than a licensed or registered/certified rehabilitation professional.

PROVIDER AND SERVICE REQUIREMENTS FOR INTENSIVE REHABILITATION SERVICES

All practitioners and providers of services shall be required to meet current state and federal licensing and/or certification requirements as follows:

A physician must: 1) complete the admission certification of intensive rehabilitation services; 2) complete initial plan of care orders; 3) complete a 60-day recertification, if applicable (or a licensed practitioner of the healing arts, such as

a nurse practitioner or a physician assistant, within the scope of his/her practice under State law). If therapy services are recertified by a practitioner of the healing arts other than a physician, supervisory requirements must be performed by a physician as required by the Virginia Department of Health Professions regulations. [Virginia State Code § 54.1-2857.02; 42 Code of Federal Regulations, 456.60 (a)(1)(b)(1), 456.80 (a)].

A physician is responsible for all documentation requirements, including but not limited to, admission certifications, recertifications, plan of care orders, progress notes, etc., as defined in this Chapter and in Chapter VI of this manual. [42 Code of Federal Regulations, 485.58 (a)(1)]. NOTE: CORF provider requirements do not permit a nurse practitioner or a physician assistant to order intensive rehabilitation services.

Physician

Physician services require that the physician have special knowledge and clinical skills and experience in the field of rehabilitation or another related field, be licensed by the Virginia Board of Medicine, be legally authorized to practice, and act within the scope of his or her license.

The physician must meet all of the following requirements:

- Provide evidence of a written physician admission certification statement (DMAS-127) and, if applicable, a physician recertification statement (DMAS-128) every 60 days;
- Develop the initial plan of care orders/treatment plans for rehabilitative therapy services to include specific procedures and modalities;
- Identify the specific discipline(s) to carry out the plan of care/treatment plan;
- Indicate the frequency and duration of services (i.e.: 1 hour daily for 5 days per week for a 4 week estimated length of stay);
- Participate at least biweekly in treatment plan reviews and interdisciplinary team conferences;
- Consult with team disciplines, as needed, in providing a comprehensive approach to the treatment plan;
- Provide evidence of a written review (DMAS-126) of the physician plan of care orders/treatment plan every 60 days;
- Complete a discharge order upon the individual's discharge from rehabilitation services.

NOTE: Refer to Chapter Six of this manual for more information on the DMAS-126, 127 and 128 physician forms.

Rehabilitative Nursing

Rehabilitative nursing services require that nurses have education, training, and/or experience which provide special knowledge and clinical skills to diagnose nursing needs and treat individuals who have health problems characterized by alterations in cognitive and functional ability. Rehabilitative nursing services are those services provided to an individual which meet all of the following conditions:

- The services shall be directly and specifically related to an active written plan of care/treatment plan approved by a physician;
- The services shall be of a level of complexity and sophistication, or the condition of the individual shall be of a nature that the services can only be performed by a registered nurse, licensed professional nurse, nursing assistant, or rehabilitation technician under the direct supervision of a registered nurse who is experienced in rehabilitation;
- The services shall be provided with the expectation, based on the assessment made by the physician that the condition of the individual will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis;
- The services shall be specific and provide effective treatment for the individual's condition in accordance with accepted standards of medical practice and include the intensity of rehabilitative nursing services, which can only be provided in an intensive rehabilitative setting; and
- Once the individual no longer requires rehabilitative nursing services, the registered nurse (RN) or the licensed practical nurse (LPN) under the supervision of an RN, must complete a discharge summary.

Physical Therapy

Physical Therapy services are those services provided to an individual that meet all of the following conditions:

- The services must be directly and specifically related to an active written plan of care/treatment plan designed by a physician after any needed consultation with a physical therapist (LPT) licensed by the Virginia Board of Physical Therapy. (12 VAC 30-60-120 and 18 VAC 112-20-30). The *Code of Federal Regulations* (42 CFR 440.110) require that the therapist meet licensure requirements within the scope of the practice under State law;
- The services must be of a level of complexity and sophistication or the condition of the individual shall be of a nature that the services can only be performed by a licensed physical therapist or a physical therapy assistant, (LPTA) who is licensed by the Virginia Board of Physical Therapy, under the direct supervision of a qualified physical therapist (18 VAC 112-20-100);
- The services shall be provided with the expectation, based on the assessment made by the physician, that the condition of the individual will improve significantly in a reasonable and generally predictable period of time, or the services shall be necessary to establish a safe and effective maintenance

program required in connection with a specific diagnosis; and

- The services must be specific and provide effective treatment for the individual's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

NOTE: Physical therapy that can be performed by supportive personnel (such as physical therapy aides, nursing staff, volunteers, etc.) does not meet DMAS criteria for reimbursement as physical therapy services. There is no provision for Medicaid reimbursement for students rendering physical therapy services.

Only a licensed physical therapist has the knowledge, training, and experience required to evaluate and, as necessary, re-evaluate an individual's level of function, determine whether a physical therapy program could reasonably be expected to improve, restore, or compensate for lost function; and, where appropriate, recommend to the physician a plan of care/treatment plan. However, while the skills of a licensed physical therapist (LPT) are required to evaluate the individual's level of function and develop a plan of care/treatment plan, the implementation of the plan may be carried out by a licensed physical therapy assistant (LPTA) functioning under the direct supervision of a licensed physical therapist.

NOTE: For more information on 30-day supervision documentation requirements, refer to the section after speech-language therapy in this chapter and Chapter VI of this manual.

If an adequate number of qualified personnel are not available to carry out the physician order, particularly related to the frequency of service, the therapist will inform the physician of this fact and document the response of the physician in the medical record. The plan of care will be revised accordingly with physician written approval.

Physical therapy is not required to improve or restore function where an individual suffers a temporary loss or reduction of function (e.g., temporary weakness which may follow prolonged bed rest following major abdominal surgery) that could reasonably be expected to spontaneously improve as the individual gradually resumes normal activities. Physical therapy for temporary loss of function will not be covered.

Once the individual no longer requires therapy services, the LPT must complete a discharge summary documenting the individual's goal achievements and outcomes and any recommendations.

Physical Therapy includes, but is not limited to, the following modalities and procedures:

These modalities are appropriate for both intensive rehabilitation services and for outpatient rehabilitation services. This list is not all inclusive.

- Gait Training; Ambulation activities
- Range of Motion Activities
- Ultrasound, Shortwave, and Microwave Diathermy Treatments
- Therapeutic Exercises (e.g., strengthening, stretching, tilt table activities, etc.)
- Hot Pack, Hydrocollator, Infrared Treatments, and Whirlpool Baths

Maintenance Activities – Not Reimbursed

Exercises or maintenance activities (e.g.: active or passive range of motion, that are not related to the restoration of a specific loss of function) can ordinarily be provided safely by supportive personnel (such as physical therapy aides, nursing staff, volunteers, etc.), and do not require the skills of a licensed physical therapist or licensed physical therapy assistant. These activities will not be reimbursed. For example, passive exercises to maintain range of motion in paralyzed extremities, can be carried out by physical therapy aides or nursing staff, and will not be considered rehabilitation therapy requiring the skills of licensed therapy staff and, therefore, will not be reimbursed.

Occupational Therapy

Occupational therapy services are those services provided to an individual that meet all of the following conditions:

- The services must be directly and specifically related to an active written plan of care/treatment plan designed by the physician after any needed consultation with an occupational therapist registered and licensed (OTR) by the National Board for Certification in Occupational Therapy and licensed by the Virginia Board of Medicine (12 VAC 30-60-120 and 18 VAC 85-80-10 et seq.). The *Code of Federal Regulations* (42 CFR 440.110) requires that the therapist meet licensure requirements within the scope of the practice under state law;
- The services shall be of a level of complexity and sophistication or the condition of the individual must be of a nature that the services can only be performed by a licensed occupational therapist or an occupational therapy assistant (COTA) certified by the National Board for Certification in Occupational Therapy under the direct supervision of a qualified occupational therapist;
- The services shall be provided with the expectation, based on the assessment made by the physician, that the condition of the individual will improve significantly in a reasonably and generally predictable period of time, or the services shall be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis; and
- The services must be specific and provide effective treatment for the individual's condition in accordance with accepted standards of medical practices; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

NOTE: Occupational therapy that can be performed by supportive personnel (such as occupational therapy aides, nursing staff, volunteers, etc.) does

not meet DMAS criteria for reimbursement as occupational therapy services. There is no provision for Medicaid reimbursement for students rendering therapy services.

Only a registered and licensed occupational therapist has the knowledge, training, and experience required to evaluate and, as necessary, re-evaluate an individual's level of function; determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function; and, where appropriate, recommend to the physician a plan of care/treatment plan. However, while the skills of a registered and licensed occupational therapist are required to evaluate the individual's level of function and develop a plan of care/treatment plan, the implementation of the plan may be carried out by a certified occupational therapy assistant (COTA) functioning under the direct supervision of a registered and licensed occupational therapist.

NOTE: For more information on 30-day supervision documentation requirements, refer

to the section after speech-language therapy in this chapter and Chapter VI of this manual.

If an adequate number of qualified personnel are not available to carry out the physician order, particularly related to the frequency of service, the therapist will inform the physician of this fact and document the response of the physician in the medical record. The plan of care will be revised accordingly with physician written approval.

Once the individual no longer requires therapy services, the OTR must complete a discharge summary documenting the individual's goal achievements and outcomes and any recommendations.

Occupational therapy includes, but is not limited to, the following modalities and procedures:

These modalities are appropriate for both intensive rehabilitation services and for outpatient rehabilitation services. This list is not all inclusive.

- The evaluation and re-evaluation, as required, to assess an individual's level of function by administering diagnostic and prognostic tests;
- The selection and teaching of task-oriented therapeutic activities designed to restore physical function;
- The planning, implementing, and supervising of an individualized therapeutic activity program as part of an overall active treatment program (e.g., the use of computer activities that require following multi-level directions, and assist with memory loss);
- The planning and implementing of therapeutic tasks and activities to restore sensory-integrative function (e.g., providing motor and tactile activities to increase sensory input and improve response); and

- The teaching of compensatory techniques to improve the level of independence in the activities of daily living.

Speech-Language Pathology

Speech-language pathology services are those services provided to an individual that meet all of the following conditions:

- Services are directly and specifically related to an active written plan of care/treatment plan designed by a physician after any needed consultation with a speech-language pathologist with a Master's degree, licensed by the Virginia Department of Health Professions, Virginia Board of Audiology and Speech-Language Pathology (12 VAC 30-60-120 and 18 VAC 30-20-170). The *Code of Federal Regulations* (42 CFR § 440.110) require that the therapist meet licensure requirements within the scope of the practice under state law;
- Services are of a level of complexity and sophistication or the condition of the individual must be of a nature that the services can only be performed by any one of the following:
- A speech-language pathologist (SLP) with a Master's Degree who is licensed by the Virginia Department of Health Professions, Virginia Board of Audiology and Speech-Language Pathology; **or**
- An individual licensed by the Virginia Board of Audiology and Speech-Language Pathology who meets one of the following:
 - a) Has a Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association (ASHA); **or**
 - b) Has completed the Masters level academic program and is acquiring supervised work experience to qualify for the ASHA certification.

This individual is in the Clinical Fellowship Year (CFY), and is under the direct supervision of a licensed CCC/SLP or SLP, which includes initial direction and periodic observation of the actual performance of the therapeutic activity. When services are provided by a CFY/SLP, a licensed CCC/SLP or SLP must make a supervisory visit at least every 30 days while therapy is being conducted and document accordingly;

- c) DMAS will reimburse for the provision of speech-language services when provided by a speech-language assistant who has either a Bachelors level or a Masters level without licensure by the Board of Audiology and Speech Language Pathology. The unlicensed assistant (and the fact that they do not meet qualification requirements to bill Medicaid) shall be disclosed to the individual, their family, caregiver, or legally authorized representative prior to treatment, and documented and made a part of the individual's record. In order to bill Medicaid, these speech-language assistants must be under the direct supervision of a licensed CCC/SLP or SLP that meets DMAS' licensure requirements.

The services must be provided with the expectation, based on the assessment

made by the physician of the individual's rehabilitation potential, that the individual's condition will improve significantly in a reasonable and generally predictable period of time, or the services are to establish a safe and effective maintenance program in connection with a specific diagnosis; and

The services must be specific and provide effective treatment for the individual's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

NOTE: Speech-language pathology services that can be performed by supportive personnel (such as speech aides, nursing staff, volunteers, etc.) does not meet the DMAS criteria for reimbursement as speech-language pathology services. There is no provision for Medicaid reimbursement for students rendering therapy services.

Only a licensed speech-language pathologist has the knowledge, training, and experience required to evaluate and, as necessary, re-evaluate an individual's level of function; determine whether a speech-language therapy program could reasonably be expected to improve, restore, or compensate for lost function; and, where appropriate, recommend to the physician a plan of care/treatment plan. However, while the skills of a qualified speech-language therapist are required to evaluate the individual's level of function and develop a plan of care/treatment plan, the implementation of the plan may be carried out by a speech-language assistant functioning under the direct supervision of a qualified speech-language therapist.

NOTE: For more information on 30-day supervision documentation requirements, Refer to the section after speech-language therapy in this chapter and Chapter Six of this manual.

A licensed speech-language pathologist is required to evaluate an individual's level of function and develop and sign/date a plan of care/treatment plan. The implementation of the plan may be carried out by one of the following: SLP, CCC/SLP, and CFY/SLP, or speech-language assistants as identified above.

If an adequate number of qualified personnel are not available to carry out the physician order, particularly related to the frequency of service, the therapist will inform the physician and document the response of the physician in the medical record. The plan of care will be revised accordingly with physician written approval.

Once the individual no longer requires therapy services, the SLP must complete a discharge summary documenting the individual's goal achievements and outcomes and any recommendations.

Speech-language pathology services include, but are not limited to, the following

modalities and procedures:

These modalities are appropriate for both intensive rehabilitation services and for outpatient rehabilitation services. This list is not all inclusive.

- Assistance to the physician in evaluating individuals to determine the type of speech or language disorder and the appropriate corrective therapy.
- Rehabilitative services for speech, language, voice, or communication disorders, language comprehension and expression (i.e.: receptive and expressive language).
- Rehabilitative services for swallowing disorders, cognitive problems, speech fluency and sound production (i.e.: articulation, phonological process, apraxia, dysarthria), etc.

Reimbursement for speech-language pathology services is limited to those services related to a medical diagnosis. *Long-term* speech-language pathology services are not covered under intensive inpatient rehabilitation but may be covered under outpatient rehabilitation services based on the individual's diagnosis, progress and treatment plan.

Therapist Supervision of a Therapy Assistant (Applicable to PT, OT, and SLP)

[Applicable for Intensive, CORF, and Outpatient Rehabilitation]

Direct on-site supervision by a qualified therapist includes initial direction and periodic observation of the actual performance of the therapeutic activity. The plan of care/treatment plan must be developed and signed by the licensed therapist (not the therapy assistant). When services are provided by a licensed or certified therapy assistant (i.e.: PTA, COTA, CFY/SLP or Speech-Language Assistant), the licensed therapist (i.e.: PT, OT, or SLP) must conduct an on-site supervisory visit at least every 30 days while therapy is being conducted, observe, and document accordingly.

If the supervisory therapist co-signs the assistant's progress visit notes, this action alone does not constitute a 30-day supervisory visit note. The supervisory therapist shall review the progress notes of the therapy assistant. The supervisory therapist documentation of the 30-day note shall include a review of the plan of care with the assistant and comments on any adjustments or revisions to the individual's therapy goals, as needed. If no adjustments or revisions are needed, the therapist should document accordingly. The supervisory 30-day review note must be signed, titled and fully dated by the therapist. Lack of documentation of the 30-day supervisory visit notes will result in a DMAS audit retraction of provider reimbursement.

Cognitive Rehabilitation Therapy

The provision of cognitive rehabilitation is included in *the State Plan for Medical Assistance* as a component of rehabilitation for severely neurologically impaired individuals, such as, for example, those with traumatic brain injury (TBI), severe

cerebral vascular accident (CVA; stroke), anoxic injuries, and intracranial hemorrhage.

Cognitive rehabilitation services are those services furnished to an individual that meet all of the following conditions:

- The services are directly and specifically related to an active written plan of care/treatment plan designed by the physician after any needed consultation with a Virginia licensed clinical psychologist or physician experienced in working with the neurologically impaired;
- The services are of a level of complexity and sophistication or the condition of the individual must be of a nature that the services can only be performed by a clinical psychologist or physician experienced in the administration of neuropsychological assessments and licensed by the Virginia Board of Medicine;
- Cognitive rehabilitation therapy services may be provided by occupational therapists, speech-language pathologists, and master's level psychologists with experience working with the neurologically impaired when provided under a plan of care/treatment plan recommended and coordinated by a physician or clinical psychologist licensed by the Virginia Board of Medicine. The plan of care/treatment plan must be prepared with the assistance and input of any specialist who may be called upon to provide services pursuant to the plan.
- The licensed clinical psychologist or the physician must provide supervision of the SLP, OT, and/or the master's level psychologist. The plan of care must be reviewed by the licensed clinical psychologist or the physician with the treating therapist and revised as needed, but at least every 30 days. When the individual no longer requires therapy services, the licensed therapist must complete a discharge summary.

When the treating therapist is working with the individual, if consultation is needed, the licensed supervising psychologist or the physician must be available or accessible. Evidence of the supervisory visit must be documented at least every 30 days in the medical record. The supervisory documentation shall include review of the plan of care and any adjustments or revisions to the patient goals, as needed. The supervisory visit review note must be signed, titled and fully dated by the supervising psychologist or the physician.

- The cognitive rehabilitation services must be an integrated part of the total individual care plan and must relate to information processing deficits that are a consequence of and related to a neurologic event;
- The cognitive rehabilitation services include activities to improve a variety of cognitive functions such as orientation, attention/concentration, reasoning, memory, discrimination, and behavior; and
- The services must be provided with the expectation, based on the

assessment made by the physician of the individual's rehabilitation potential, that the condition of the individual will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis.

Psychology, Social Work, and Therapeutic Recreation Services

These services provided to an individual must meet all of the following conditions:

- The services must be directly and specifically related to an active written plan of care/treatment plan ordered by a physician;
- The services must be of a level of complexity and sophistication or the condition of the individual must be of a nature that the services can only be performed by:
 - Psychology - a qualified clinical psychologist (Ph.D. or Psy.D.), or by a licensed clinical social worker (LCSW), or a licensed professional counselor (LPC); or a clinical nurse specialist-psychiatric, all licensed and certified by the appropriate Board under the Virginia Department of Health Professions.
 - Social Work - a qualified licensed social worker as required by the Virginia Department of Health Professions, Board of Social Work.
 - Therapeutic Recreation - a certified therapeutic recreation specialist (CTRS) with the National Council for Therapeutic Recreation at the professional level.
- The services must be provided with the expectation, based on the assessment made by the physician that the condition of the individual will improve significantly in a reasonable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis;
- The services must be specific and provide effective treatment for the individual's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services must be reasonable; and
- When the individual no longer requires therapy services, the discipline providing services must complete a discharge summary.

Prosthetic and Orthotic Services and Other Equipment

Prosthetic Devices

Prosthetic services include prosthetic devices that replace all or part of an external body part and services necessary to design the device, including measuring, fitting,

and instructing the individual in its use. Prosthetic arms, legs, breast(s) and their supportive devices are covered for all Medicaid individuals, and require service authorization by the DMAS service authorization contractor.

For further instructions, refer to the “Coverage and Limitations” section in Chapter IV of the *Prosthetic Device Manual* located on the DMAS Medicaid Web Portal at: <https://www.viriniamedicaid.dmas.virginia.gov/wps/portal> .

Orthotic Devices

Orthotic device services include devices that support or align extremities to prevent or correct abnormalities or improve functioning and services necessary to design the device, including measuring, fitting, and instructing the individual in its use.

Items made for the individual by an occupational therapist, including splints, slings, and any normally stocked supplies, are part of the cost of the DMAS approved outpatient rehabilitation visit. These items are billed as ancillary charges on the UB-92, HCFA-1450 - Universal Claim Form.

Orthotics, including braces, splints, and supports, are not covered items for the general Adult Medicaid population (age 21 and over) under the Durable Medical Equipment and Supplies program, with the exception of the Intensive Rehabilitation program as described below.

Intensive Rehabilitation Program – Orthotic Devices

Coverage for both adults and children is available for medically necessary orthotics when recommended as part of an approved intensive inpatient rehabilitation program (including CORF), and when all of the following DME criteria are satisfied via adequate and verifiable documentation which must include:

- Ordered by the practitioner on the DMAS-352 (CMN – Certificate of Medical Necessity);
- Directly and specifically related to an active, written, and practitioner-approved rehabilitation treatment or discharge plan;
- Based upon a practitioner’s assessment of the individual’s rehabilitation potential, where the individual’s condition will improve significantly in a reasonable and predictable period of time, or shall be necessary to establish an improved functional state of maintenance; and
- Consistent with generally accepted professional medical standards (i.e., not

experimental or investigational).

NOTE: For further instructions on orthotic coverage, refer to Chapter IV of the *DME*

and Supplies Manual located on the DMAS Medicaid Web Portal at:
<https://www.viriniamedicaid.dmas.virginia.gov/wps/portal>.

EPSDT – Early Periodic Screening Diagnosis and Treatment Program
(For Children Under 21 Years of Age)

All medically necessary orthotics are covered for children under the age of 21 years. The same program guidelines, as identified in the above paragraph, apply to this category.

Other Medical Equipment Needs

Durable medical equipment (DME) and supplies required during the rehabilitation stay are included in the per diem rate, and entered on the rehabilitation hospital bill as ancillary services.

Durable Medical Equipment required for in-home use or to facilitate the individual's discharge home or discharge to an Adult Living Facility (ALF) may be covered under the DME and Supplies program. Refer to the DME and Supplies Manual on the DMAS Medicaid web portal. Chapter IV of the DME Manual lists covered services and limitations and the numerous appendices list the covered equipment and supplies.

For individuals who previously resided in a nursing facility or will be discharged from the hospital to a nursing facility, refer to the *Nursing Facility Manual*, Chapter IV, on the DMAS Medicaid Web Portal for DME coverage guidelines.

OUTPATIENT REHABILITATION SERVICES

The outpatient rehabilitation program criteria and policy guidelines can be found in the *Virginia Administrative Code*, 12 VAC 30-50-200 and 12 VAC 30-60-150. Effective January 1, 2016, these two sets of outpatient rehabilitation regulations were revised. The following outpatient rehabilitation regulations: 12 VAC 30-130-10, 15, 20, 30, 40, 42, 50, and 60 were repealed as they were repetitive, outdated, or obsolete. Rehabilitation providers have a responsibility to know the regulatory requirements for rehabilitation.

Definition of an Outpatient Rehabilitation Therapy Visit

An outpatient therapy visit is the treatment session in which a rehabilitation therapist provides the individual services prescribed by a physician or other licensed practitioner of the healing arts. Reimbursement is made on a per visit basis. The furnishing of any services by a rehabilitation therapist on a particular day or a particular time of day constitutes a visit. For example, if both a physical therapist and an occupational therapist furnish services on the same day, this

constitutes two visits - one each of physical therapy and occupational therapy. If a therapist furnishes several modalities/interventions during a visit, this constitutes only one visit. However, if a therapist provides two distinctly separate therapy visits/sessions during the same day (e.g., a morning session and an afternoon session), this would constitute two visits.

Combined visits by more than one therapist cannot be billed as separate visits if the goal(s) of the therapists is the same for that visit (e.g., two therapists are required to perform a single procedure). The overall goal(s) of the sessions determines how the visit can be billed.

Group Therapy: Medicaid will reimburse for group therapy, regardless of payer source, for a minimum of two but no more than six (6) individuals.

Admission Criteria

DMAS requires the following for Outpatient Rehabilitation Services:

- The participant must meet InterQual® criteria upon admission and for continued services. The InterQual® criteria may be obtained through McKesson Health Solutions LLC.
- For the current McKesson mailing address, phone and fax numbers and the InterQual® web site address, refer to Appendix D. of this manual, which contains the service authorization information.

In addition to the InterQual® criteria requirements, eligibility for general outpatient rehabilitative services is based on the individual's medical need for one or more of the following covered services: physical therapy, occupational therapy, or speech-language pathology services. A physician or other licensed practitioner of the healing arts, such as a nurse practitioner or a physician assistant, within the scope of his/her practice under State law, must prescribe these services.

Rehabilitation services is medically prescribed treatment for improving or restoring functions that have been impaired by illness or injury, or where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning. Rehabilitation services for speech impairments secondary to developmental delays, autism, and other related communication disorders are also covered services.

Admissions for evaluation and/or training solely for vocational or educational purposes or for developmental or behavioral assessments are not covered services.

Any one of these therapy services (PT, OT or Speech) may be offered as the sole rehabilitative service and shall not be contingent upon the provision of another service. Medicaid covers general outpatient rehabilitative services provided in outpatient settings of acute and rehabilitation hospitals, nursing facilities, home health agencies, and rehabilitation agencies. All providers must have a provider agreement with the Department of Medical Assistance Services (DMAS).

All practitioners and providers of services shall be required to meet state and federal licensing and certification requirements. Services not specifically

documented in the individual's medical record as having been rendered shall be deemed not to have been rendered, and no payment shall be provided.

Providers of Service

A physician or other licensed practitioner of the healing arts, such as a nurse practitioner or a physician assistant, within the scope of his/her practice under State law, may order services, develop the plan of care, and complete physician initial certification and recertifications under the direct supervision of a physician. If therapy services are ordered by a practitioner of the healing arts other than a physician, supervisory requirements must be performed by a physician as required by the Virginia Department of Health Professions regulations. (Virginia State Code § 54.1-2957.02; 42 Code of Federal Regulations, 440.130 (d), 485.711)

Therapist Qualifications and Therapy Modalities – Refer to Intensive Rehab Section

The qualifications for physical therapists, occupational therapists, and speech-language pathologists, as well as therapy modalities and treatment procedures, are defined in the ***Intensive Rehabilitation section*** of this chapter. The same qualifications apply to outpatient rehabilitation providers. Refer to this section for more information. The same section also includes supervision documentation requirements for therapy assistants as does Chapter VI of this manual.

Guidelines for Initiating and Continuing Therapy

[Applicable for both Inpatient & Outpatient Rehabilitation]

- *Maintenance Therapy* - Interpreted as: 1) the point in therapy where the individual demonstrates no further significant improvement, or 2) the skills of a qualified rehabilitative therapist are not required to carry out an activity or a home program to maintain functioning at the level to which it has been restored. These services are not covered by Medicaid.
- *Improvement of Function* – Interpreted as rehabilitative therapy designed to improve function and based on an expectation that: 1) the therapy will result in a significant improvement in an individual's level of functioning within a reasonable period of time; 2) there is a valid expectation of improvement at the time the rehabilitative therapy program is implemented; and 3) the services would be recognized even though the expectation may not be realized.

For continued intensive rehabilitation services, the individual must demonstrate an ability to actively participate in goal-related therapeutic interventions developed by the interdisciplinary team and demonstrate progression toward the established goals.

Coordination of Rehabilitation Services

The purpose of coordination of services is to maximize therapy benefits for the individual. Coordination of services between treating therapists should be done when an individual receives therapies from two separate rehabilitation providers (i.e., school and after-school therapies). Coordination of services allows two treatment therapists to guarantee maximum benefit of services for the individual is achieved based on the treatment plans. When two separate rehabilitation providers are not coordinating services, the treatment plans may be in conflict with the desired individual's outcome.

Therapists do have a professional responsibility to keep physicians and parents/caregivers informed of each individual's rehabilitation progress. Coordination of services will be reviewed by the DMAS Service Authorization (SA) contractor through the SA process and by DMAS for compliance during utilization review activities.

Categorization of Two Subgroups: Acute vs Non-Acute Conditions

There are two subgroups in general outpatient rehabilitation: acute conditions and long-term, non-acute conditions.

- **Acute conditions** are defined as those conditions which are expected to require rehabilitative services for a duration of less than twelve (12) months, and in which progress toward established goals is likely to occur frequently.
- **Long-term, non-acute conditions** are defined as those conditions which are expected to require rehabilitative services for a duration of greater than twelve (12) months, and in which progress toward established goals is likely to occur slowly.

If the individual is appropriate for the acute sub-group, requiring rehabilitative services for less than twelve (12) months, a physician re-certification (renewal of orders and plan of care/treatment plan) is required at least every sixty (60) days. Any initial plan of care/treatment plan or periodic renewal written by the qualified therapist must be signed and dated by the physician within 21 days of implementation date of the plan.

If the individual is appropriate for the long-term, non-acute sub-group, requiring rehabilitative services for greater than twelve (12) months, a physician re-certification (renewal of orders and plan of care/treatment plan) is required at least annually. The physician must sign and date the order/plan of care/treatment plan at the time of review/renewal prior to the initiation of the continuation of service.

Defining a condition as acute or as long-term, non-acute, is not based on an individual's diagnosis. Defining the condition is based on the length of time services are medically justified. The requirement for the development of an appropriate and realistic plan of care/treatment plan remains unchanged. Plans of care/treatment plans must still include measurable, long-term and short term goals with anticipated dates of achievement. Plans of care/treatment plans must be renewed by the physician at any time long term goals are achieved or are in need of revision, regardless of the subgroup categorization of the individual.

Discharge Planning

Discharge planning must be an integral part of the treatment plan and developed at the time treatment is initiated. The plan shall identify an anticipated safe and effective maintenance program, if applicable, and the individual's functional status and discharge outcomes. The individual or their legal representative should be involved in the discharge planning process.

Home Therapies

Licensure requirements in the State of Virginia allow only agencies that are licensed as home care organizations may provide services in the home (Code of Virginia, 32.1-162.9). An exception is providers of services for children enrolled with the Early Intervention Services (EIS) program (Part C of IDEA); they are not required to be licensed as home care organizations. [Code of Virginia, Section 2.2-5308]

If an outpatient rehabilitation agency is contracting with a school district to provide rehabilitation services to special education Medicaid children in accordance with the IEP (Individualized Education Program), which identifies home-based instruction and rehabilitation therapy services, then home therapies may be provided by the outpatient rehabilitation provider as long as the provider is licensed as a home health care agency. [8 VAC (Virginia Administrative Code) 20-131-180 and 8 VAC 20-80-10]

School districts, under contract with outpatient rehabilitation providers must bill DMAS for all rehabilitation services provided to Medicaid individuals with an IEP. Refer to the Medicaid Local Education Agency (LEA) Manual, Chapter IV, for more information regarding school rehabilitation coverage and limitations. The LEA Manual is on the Medicaid web portal at: <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>.

Therapies Provided in Nursing Facilities

DMAS provides direct reimbursement to enrolled rehabilitation providers for outpatient therapies rendered to individuals residing in nursing facilities. This reimbursement shall not be provided for any sums that the rehabilitation provider collects, or is entitled to collect, from the nursing facility or any other available source. In addition, it shall in no way diminish any obligation of the nursing facility to provide its individuals such services, as set forth in any applicable provider agreement. If a physician (or other licensed practitioner) order exists for therapies, therapies must be provided as ordered. For nursing facilities that have therapist as a part of their staff, this section is not applicable. Reasonable and necessary administrative costs will be considered under the cost settlement process for the nursing facility.

Rehabilitative Services in ICF/IID Facilities

DMAS provides direct reimbursement to enrolled rehabilitation providers for outpatient therapies rendered to individuals residing in an intermediate care facility for individuals with an intellectual disability (ICF/IID). This reimbursement shall not

be provided for any sums that the rehabilitation provider collects, or is entitled to collect, from the facility or any other available source. If rehabilitation therapists provide facility staff with instruction or consultation, this service cannot be billed to Medicaid. However, these services may be considered an administrative cost and may be billed to the ICF/IID. Reasonable and necessary administrative costs will be considered under the cost settlement process for the ICF/IID facility.

Rehabilitation Therapy – Specific Modalities

The rehabilitation treatment plan must address significant improvement of functional ability, mobility, and endurance, and not simply performing repetitious exercises or maintenance activities.

There are multiple types of modalities offered as part of a treatment plan that requires the skills of a licensed therapist and as described above, that would be an appropriate treatment plan. For a modality example, if an individual is receiving “ground” or “land” therapy in the rehabilitation agency, in addition to participation in pool therapy, this would be a rehabilitative covered service. However, water aerobics classes are not rehabilitation covered service because they do not require the skills of a licensed therapist and are to “maintain” an individual at a certain level of function attained.

Another modality example is “hippotherapy”, which is offered to an individual while riding a horse that addresses agility, gross and fine motor skills, balance and coordination. This is another modality example for a treatment plan that requires the skills of a licensed therapist.

For information regarding Day Feeding Programs or information regarding EPSDT programs for those children under age 21, refer to the DMAS agency web site located at: http://www.dmas.virginia.gov/Content_pgs/mch-home.aspx.

Discharge/Termination from Services

[Applicable for both Inpatient & Outpatient Rehabilitation]

Rehabilitation services must be considered for termination, regardless of the service authorized or approved length of stay, when further progress toward the established rehabilitation goal is unlikely or further rehabilitation treatment can be achieved in a less intensive setting, such as in nursing facilities, home and community based settings, home health agencies, and/or maintenance program.

Intensive/Inpatient rehabilitation services must be considered for termination when any one of the following conditions is met:

- No further potential for improvement is demonstrated. The specialized knowledge and skills of a licensed/registered rehabilitative therapist are no longer required for safe and effective provision of such rehabilitation services. The individual has reached his/her maximum progress and a safe and effective maintenance program has been developed;
- There is limited motivation on the part of the individual or caregiver;

- The individual has an unstable condition that affects his/her ability to participate in an intensive/inpatient comprehensive rehabilitative plan;
- Progress toward an established goal or goals cannot be achieved within a reasonable period of time;
- The established goals serve no purpose to increase functional or cognitive capabilities; or
- The service can be provided by someone other than a licensed or registered/certified-rehabilitation professional.